Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $925.00 for date of service, 6-21-01.

   b. The request was received on 4-25-01.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. HCFA 1500
   c. EOBs
   d. Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 6-7-02. There is no response from the Requestor in the file. A "No Additional Information Received" from the Requestor is reflected in Exhibit I.
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 6-11-02. There is no Carrier initial or 14 day response to this medical fee dispute in the file.

III. PARTIES' POSITIONS

1. Requestor: No position statement.

2. Respondent: No position statement.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 6-21-01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $1,350.00.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $425.00.

5. According to the Table of Disputed Services the amount in dispute is $925.00.

V. RATIONALE

Medical Review Division's rationale:

The Requestor has submitted a HCFA 1500 which reflects billing for CPT Code 27299-51 and 22899-51. CPT Code 27299 is a DOP procedure defined as, "unlisted procedure, pelvis or hip joint"; CPT Code 22899 is a DOP procedure defined as, "unlisted procedure spine".

The carrier has denied the charges in dispute as " F – REDUCTION ACCORDING TO FEE GUIDELINES…F – REIMBURSEMENT FOR YOUR RESUBMITTED INVOICE HAS BEEN CONSIDERED. NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME. THIS BILL WAS PREVIOUSLY PAID". The Medical Review Division's decision is rendered based on denial codes submitted to the Provider prior to the date of this dispute being filed.

When determining whether or not additional reimbursement is warranted, the Medical Review Division must first determine that the services were rendered as billed. After review of the dispute file, no documentation was noted to support the services billed. **No** reimbursement is recommended.

The above Findings and Decision are hereby issued this 12th day of August 2002.

Lesa Lenart, RN
Medical Dispute Resolution Officer
Medical Review Division

LL/ll

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.